CCLHO Proposal To CDCR Receivership

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Terms

- **Reentry**: Reentry involves the use of programs targeted at promoting the effective reintegration of offenders back to communities upon release from prison and jail.
- **Receivership**: A non-profit corporation appointed by a federal job to take control of the assets of the California state prison medical system.
- **Receiver**: CEO of the receivership.
- **CDCR**: California Department of Corrections and Rehabilitation

Brief Context

- CCLHO approached by Mr. Bob Sillen, Receiver for CDCR's medical system (California Prison Health Care Receivership Corporation or CPR), to draft a proposal to help strengthen public health in California's prisons. (Seek Foundation support?)
- CCLHO has been working diligently over the past few years to reinvigorate a joint CDCR-DHS-CCLHO committee on communicable disease policies and control within CDCR.
- CPR has engaged several health care medical informatics experts and intends to enhance the availability of electronic health data, electronic registries, & telemedicine within CDCR.

Brief Context (cont.)

- Several innovative city-based programs have been developed including LA's Going Home--Los Angeles program and Oakland's Project Choice.
- Several counties (LA, San Diego, Riverside, San Bernardino, and Alameda) have been involved in an effort organized by Regional Congregations and Neighborhood Organizations (RCNO) to develop a *Public Health Reentry Initiative* to provide a seamless system of support for parolees who are seeking solutions to their health needs.
- Kern and San Diego counties HIV and mental illness case management programs for re-entering prisoners.

- It is the sense of the authors that this proposal should coordinate with these efforts, and should not be developed in a vacuum.

The Status Quo

Characteristics of Status Quo

1. Extremely high recidivism rate among CA prisoners;
2. High prevalence of public health problems in this population;
3. High prevalence of complex interwoven social needs among re-entering prisoners;
4. Multiple missed opportunities for public health screening and timely intervention in the cycle of incarceration and re-entry;
5. Poor communication across and within systems and jurisdictions; and
6. The lack of a competent public health infrastructure within CDCR.

High Recidivism Rate

- More than 95 percent of prisoners will be released to the community.
- According to a 2003 report from the California Research Bureau, 56% of California's first time parolees are returned to prisoner within 24 months.[1]

[1] Adult Parole and Probation in California, Nieto, Marcus. California Research Bureau, 2003. CRB-03-009

High Recidivism Rate

- Parolees generally are required to be released to their last county of legal residence before commitment to prison.
- Top recipient counties of re-entering prisoners in 2001: Los Angeles (35,908 or 28%), San Bernardino (10,210 or 8%), San Diego (9238 or 7%), Orange (7604 or 6%), Riverside (7196 or 6%), Alameda (6407 or 5%), and Sacramento (5916 or 5%).

High Prevalence of PH Problems

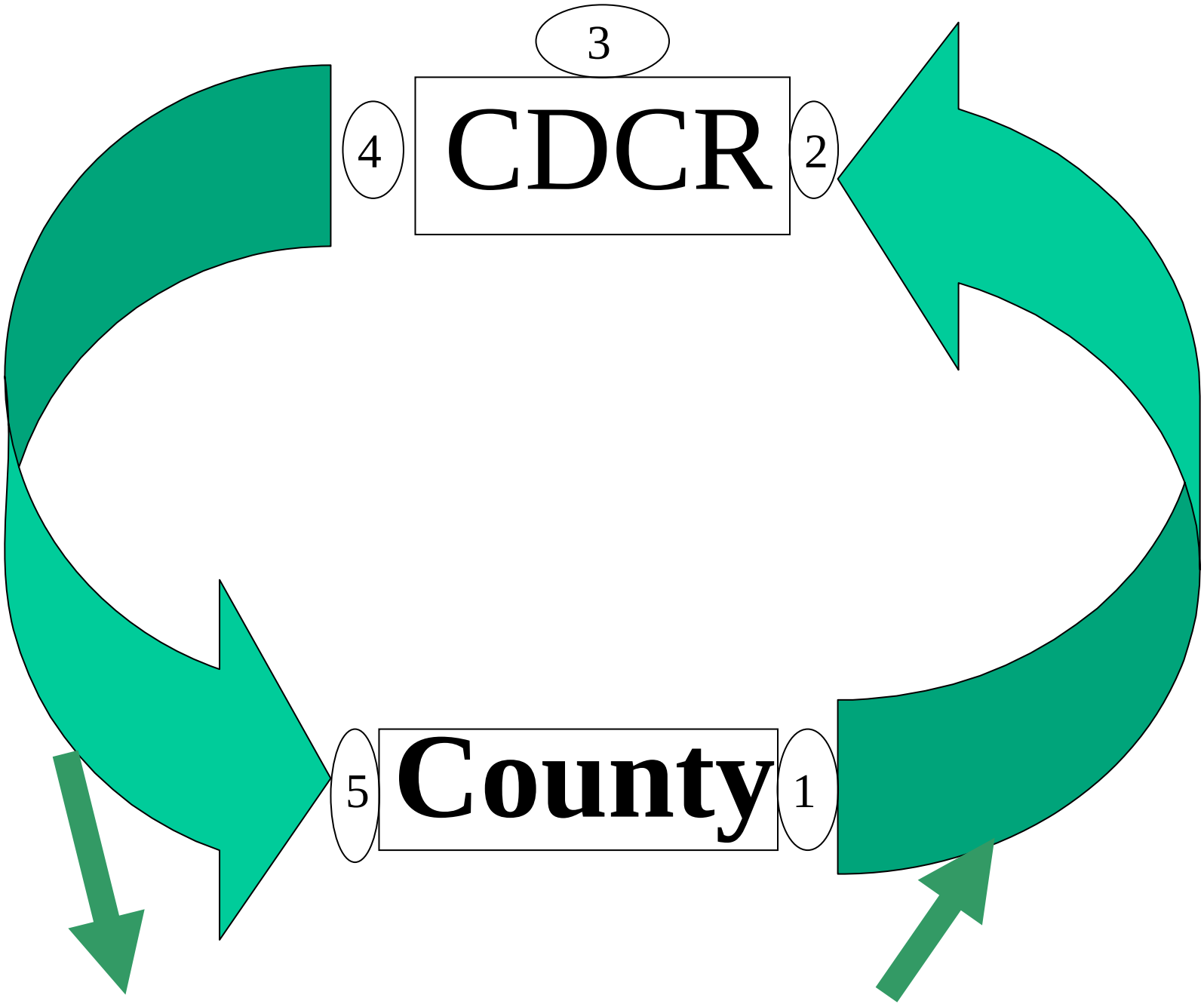
- DHS study reveals that the prevalence of hepatitis C in California prisons is 34%, hepatitis B (past infection) is 28%, hepatitis B current/chronic infection is 3.5%, and HIV prevalence is 1.8%.
- Estimates of prisoners with serious mental health suggest rates as high as 20%, while substance abuse rates are estimated to be 85%.
- Other diseases of special interest include coccidiomycosis for which specific surveillance strategies within CDCR may be indicated.

Missed Opportunities

There are 5 clear intervention points in the cycle of incarceration and re-entry into communities:

1. County Jail;
2. 2. Prison Intake;
3. 3. Incarceration;
4. 4. Anticipating Release;
5. 5. Re-Entry To Counties.

During this cycle, effective health assessment, record keeping, appropriate intervention, and inter-agency communication, is critical to optimize the use of the scarce health resources devoted to this population.


3
4
CDCR
2
5
County
1

Communication Within & Across Systems

- There is no reliable standard system of data management or medical record management in CDCR. In fact, in the court case that lead to the appointment of the receiver, findings of fact included: “Data management… practically non-existent” and “Medical records… either in a shambles or nonexistent”.
- In addition to the lack of reliable record keeping and sharing within CDCR, there is absolutely no reliable or timely system for record sharing between prisons and county public health agencies. None of these government agencies maintains comprehensive electronic medical records.

Proposed PHSU Within CDCR

- CDCR (Dr. Khoury as lead) has moved ahead to develop a set of internal recommendations and proposed structure for a Public Health Services Unit within CDCR. We strongly applaud and support this initiative and are willing to provide technical assistance as this proposal is further refined.

Proposed PHSU (cont’)

- The Public Health Services Unit (PHSU) shall be comprised of Field Operations Support, Epidemiology, Education and Disease Prevention, Public Health Disaster Response, and Legislation, Policy, and Regulations.

Proposed PHSU (cont’)

Under the Direction of the Chief Medical Officer, Public Health, the PHSU shall be responsible for performing public health activities including but not limited to:

- disease prevention
- diagnosis
- health promotion
- service delivery
- Public Health research
- education of employees and inmate patients
- development of policy and procedure

Proposed PHSU (cont’)

1.0	Medical Officer (Public Health/Infectious Disease)
1.0	Physician & Surgeon (Epidemiology/Public Health)
1.0	Nurse Consultant Program Review Lead
1.0	Correctional Health Services Administrator II
1.0	Correctional Health Services Administrator I
6.0	Public Health Nurse II
1.0	Research Manager II
3.0	Research Program Specialist I
1.0	Systems Software Specialist
1.0	Staff Services Manager I
9.0	Health Program Specialist I
4.0	Associate Health Program Analysts
4.0	Office Technician

Proposed PHSU (cont')

Regional Staffing:

2 Public Health Nurse II per Region (6 total)

1 Health Program Specialist per Region (3 total)

Field Staffing:

Northern Region:	11 Public Health Nurse/Infection Control Nurse
Central Region:	12 Public Health Nurse/Infection Control Nurse
Southern Region:	10 Public Health Nurse/Infection Control Nurse

Proposed PHSU (cont’)

Field Operation Support, working through Regional Public Health Teams, shall be responsible for providing the field staff with consultation, guidance, oversight, and technical assistance for complex epidemic or disease outbreak(s). The teams would utilize surveillance techniques to identify and prevent further transmission of the disease-causing agents.

Recommendations

Opportunities for Collaboration and Consultation

Recommendation 1

Establish a robust and competent public health infrastructure within CDCR

Recommendation 2

Work in partnership with CDCR to develop an electronic “Continuity of Care Record” (CCR), accessible to county public health departments (and DPH), that would serve as an electronic “health passport” for prisoners upon release

Recommendation 3

Establish within CDCR a pre-release screening, education, and discharge coordination process, which may include a pre-release health curriculum, community health directory, electronic transmission of medical records to receiving county, and vouchers for establishing health access in the accepting communities.

Recommendation 4

Develop a standardized medical screening at intake and pre-release that screens for chronic disease as well as communicable disease and other diseases of particular public health significance, such as hepatitis C, chronic/carrier Hepatitis B, HIV, and TB.

Recommendation 5

Work with CCLHO, CHEAC to advocate for simple reactivation of Medi-Cal benefits for those re-entering prisoners whose Medi-Cal was suspended at incarceration.

Based on discussions with health officers, knowledgeable local and state public health department staff, CDCR medical staff, Receiver's medical staff, and community based organizations involved in prison health and re-entry issues, and given the ongoing internal initiatives that CDCR is already pursuing under the Receiver's tenure, it is CCLHO's conclusion that Recommendation 2 provides the greatest opportunity for CCLHO and CDCR collaboration.